CHAPTER V

PROCEDURES FOR SPECIAL CIRCUMSTANCES

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SPLIT-SHIFT SERVICE DELIVERY

There are situations where the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening shifts). The provider agency is instructed to complete two Plans of Care, labeled morning or afternoon, to indicate each shift of services. The total number of hours on morning and afternoon Plans of Care cannot exceed the number allowed for the recipient's level of care without prior approval from DMAS. An individual receiving split-shift services is only authorized to receive the services designated for that shift. If morning services are not necessary or provided, the hours for the morning shift may not be used during the afternoon shift unless unusual circumstances warrant the additional care. Inappropriate use of hours on split-shift service delivery may result in denied reimbursement by DMAS upon audit. Providers are encouraged to contact their assigned utilization review analyst when unusual situations occur.

CHANGE IN SERVICES BY THE PROVIDER AGENCY - ADVANCE NOTICE REQUIRED

There are various financial, social, and health factors which might cause an agency to decide to terminate/increase/decrease services to a Medicaid recipient. The agency has the responsibility to make adjustments to services as indicated by any change in the recipient's needs or situation. The provider agency must give the recipient and/or family 10 days' written notification of any decision to terminate or change the amount of services received (unless the recipient requests a date which is less than 10 days and the provider documents that this is according to the recipient's request) and must indicate the specific reason(s) for the decision. If the individual does not agree with the agency's decision, the individual may request reconsideration of the decision by the Department of Medical Assistance Services.

The provider must include the following statement in every decision letter related to the termination of services or a change in the number of service hours:

> "You may request reconsideration of this decision by notifying, in writing, the Adult Services Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for a reconsideration must be filed within thirty (30) days of this notification. If you file a request for reconsideration before the effective date of this action, (date), services may continue unchanged during the reconsideration process."

When DMAS receives a request for reconsideration, the analyst responsible for review of the personal care provider will complete a preliminary evaluation as soon as possible; not

to exceed 10 working days from the date the request for reconsideration is received. This preliminary evaluation will consist of a phone contact to review with the provider RN and recipient the circumstances that created the adverse action to determine if anything has been overlooked or if there has been any change which might invalidate the adverse action decision. If it appears that something has been overlooked or there has been a change, the DMAS analyst may reverse the action taken by the provider RN. The analyst will notify the recipient of the reason the agency's decision has been overturned and provide the agency RN with a copy of the letter. If the analyst decides to uphold the agency RN's decision, the analyst will notify the recipient and RN of this in writing. Any reconsideration decision can be appealed by the recipient to the DMAS Division of Client Appeals. The analyst's notification of the reconsideration decision will contain the recipient's right to formally appeal the analyst's decision by notifying the Division of Client Appeals, Department of Medical Assistance Services.

If the analyst cannot make a determination based on the phone contacts with those involved, the analyst will send a letter to the recipient with a copy to the provider suspending the agency's action and scheduling a visit to the recipient's home and/or provider agency. After this visit, the analyst will communicate his or her decision to the recipient in writing and will send a copy of the letter to the provider.

Termination of Services

Any time the provider determines that an individual does not have functional dependencies and/or medical/nursing needs that meet the criteria for personal/respite care, the provider agency is expected to terminate service.

If the recipient's care is terminated, the provider agency must send, in addition to the letter advising the recipient of the termination and right to reconsideration, a Patient Information Form (DMAS-122) to his or her assigned analyst at DMAS and a copy to the appropriate local Department of Social Services. The DMAS-122 must note the date of termination as the last date of services rendered. In the event that a recipient's care was terminated prior to his or her request for reconsideration and the analyst decides to reinstate services, the provider must send a copy of the analyst's letter reinstating services, along with a DMAS-122, to the local Department of Social Services. The provider agency is responsible for making a reasonable effort to ensure continuity and appropriateness of care through referrals to any other appropriate sources of assistance.

Decrease in Hours

If the RN supervisor has determined that a decrease in hours of service is warranted, the RN supervisor must discuss the decrease in hours with the recipient and/or family during a home visit, not by telephone, and document the visit and conversation in the recipient's record. The provider agency is responsible for developing the new Plan of Care (DMAS-97A) and notifying the recipient or family by letter. This letter must state the **specific reasons** for the decrease, the new number of hours to be provided per week,

the effective date of the decrease in hours, and the **Right to Reconsideration** statement. A copy of this letter must be filed in the recipient's record. The provider agency must send a copy of the revised DMAS-97A and the recipient letter to its assigned analyst at DMAS.

If the recipient requests a decrease in hours by phone, the RN supervisor is not required to make an extra visit to the recipient's home. The RN supervisor may send a letter confirming the recipient's request, the new number of hours, and the effective date of the change.

Increase in Hours

The provider is able to establish the amount of service in the Plan of Care which is appropriate to meet the recipient's needs as long as the maximum number of hours per week for that recipient's level of care is not exceeded. Under no circumstances can the recipient receive more hours of care than his or her level of care allows without prior approval from DMAS. If a change in the recipient's condition (physical, mental, or social) indicates that either supervision needs to be added to the Plan of Care or the recipient's level of care has changed and an increase to the Plan of Care is needed for more than the amount allowed according to the recipient's current level of care, **the provider agency must mail to the DMAS utilization review analyst assigned to the provider agency an updated DMAS-97A and any other documentation necessary to justify the need for and use of hours. The DMAS analyst must authorize the change in the recipient's level of care or addition of supervision services and corresponding increase in hours.**

The DMAS analyst may authorize the increase in hours by telephone, and the provider agency must note this decision in the recipient's record. DMAS will send a letter to the recipient confirming approval of the increase in hours and providing the recipient the right to appeal the decision. DMAS will send a copy of this letter within 10 working days confirming approval of the change in level of care and increase to the provider agency to be filed in the recipient's record.

If DMAS does not approve the request to change the level of care and increase the hours (whether the increase is requested by the recipient or on the recipient's behalf by the personal care provider agency), the letter to the recipient must indicate the reason the change was not made. This letter must also give the recipient notification of his or her right to appeal this decision. DMAS will send a copy of this letter to the provider agency.

TERMINATION OF PERSONAL CARE SERVICES BY THE PROVIDER AGENCY - ADVANCE NOTICE NOT REQUIRED

Personal care services may be terminated immediately by the provider, without prior notice, if the agency's personnel are in immediate danger, the recipient requests immediate termination of services or the provider does not have staff available to render care and is not able to secure a substitute aide or transfer services. This does not include

those situations in which the provider has some concerns about the recipient's health and safety. In these situations, the provider should detail to the DMAS utilization review analyst his or her concerns and continue to provide services pending a decision by the analyst regarding the recipient's continued appropriateness for personal care services.

When the provider determines that the recipient or the recipient's environment presents an immediate danger to personnel, the DMAS utilization review analyst must be notified immediately by telephone. In addition, a letter must be written to the recipient stating that services will be or have been terminated. This letter must state the effective date of termination and an accurate statement regarding the reason for termination. This letter must provide the recipient with the address and telephone number for DMAS. The DMAS utilization review analyst will promptly evaluate the situation and make a determination of whether services continue to be appropriate. If DMAS decides that services continue to be appropriate, DMAS will advise the recipient to contact another approved personal/respite care provider for continued services. A copy of the letter must be filed in the recipient's record and a copy of the letter with a DMAS-122 (Patient Information form) must be sent to the Community-Based Care Section of DMAS. A copy of the DMAS-122 must be sent to the appropriate local Department of Social Services, giving the termination date as the last date of service rendered.

TERMINATION OF PERSONAL/RESPITE CARE SERVICES BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

DMAS may terminate personal/respite care services for any of the reasons stated below, or for any other reason which might apply:

- Personal/respite care is not the critical alternative to prevent or delay institutional placement;
- The recipient no longer meets community-based care criteria;
- The recipient's home does not provide for the recipient's health, safety, and welfare; or
- An appropriate personal/respite care Plan of Care cannot be developed.

The provider agency and the recipient will be notified in writing if personal/respite care services are to be terminated. The effective date of termination will be at least 10 days from the date of the termination notification letter. The provider agency will receive a copy of the decision letter sent to the recipient. The recipient has the right to appeal any action taken by DMAS to terminate services. An appeal filed by the recipient prior to the date of termination entitles the recipient to continued services during the appeal process. If, however, the DMAS decision is upheld by the Division of Client Appeals, the recipient must reimburse Medicaid for all services received following the original date of termination. The provider will be notified in the event of an appeal and advised as to whether to continue previous services and bill Medicaid during the appeal process.

SUSPECTED ABUSE OR NEGLECT

If the provider agency knows or suspects that the personal/respite care recipient is being abused, neglected, or exploited, State law (Title 63.1-55.3, Code of Virginia) mandates that the party having knowledge or suspicion of the abuse/neglect/exploitation report this to the local Department of Social Services. The Department of Social Services is responsible for the investigation of the alleged abuse/neglect/exploitation.

The contact with the Department of Social Services may be made anonymously, but the personal/respite care record must note the alleged abuse/neglect and state that the appropriate report has been made.

MEDICAID APPLICATION PENDING

The Department of Medical Assistance Services **cannot reimburse** for personal/respite care services rendered if:

- The individual has not been assessed and approved for personal/respite care through the Nursing Home Pre-Admission Screening process;
- The individual is not financially Medicaid-eligible on the dates that services are rendered; and
- The individual has not received services that are covered under personal/respite care as defined by DMAS.

There will be cases where the individual has been assessed and approved for services through the Nursing Home Pre-Admission Screening process, but final financial Medicaid eligibility has not been determined. In these cases, the provider may wish to provide personal care services, as approved by Nursing Home Pre-Admission Screening, while awaiting the final eligibility decision by the local Department of Social Services regarding Medicaid financial eligibility. The provider cannot bill and is not guaranteed Medicaid reimbursement for services provided until the provider verifies that Medicaid has been approved via either a DMAS-122 from the local Department of Social Services or by viewing the recipient's Medicaid card or by calling the REVS line.

If the individual is determined to be financially Medicaid-eligible, the date of Medicaid financial eligibility may be retroactive (the effective eligibility date established as being prior to the date of approval of the Medicaid application).

DMAS will reimburse the personal care provider agency to the retroactive date of eligibility, **if and only if,** all DMAS personal/respite care regulations and policies have been followed. The provider agency must have all Nursing Home Pre-Admission Screening forms, Provider Agency Plan of Care (DMAS-97A), RN supervisory notes, and personal/respite care Aide Records (DMAS-90) documentation. **DMAS will not reimburse for the following personal/respite care services:**

- Those which cannot be verified on the DMAS-90;
- Those which were rendered prior to the date of authorization and physician certification on the DMAS-96; and
- Those which were rendered prior to the effective date of financial Medicaid eligibility.

ADDITIONAL SERVICES - NON-PERSONAL CARE

A recipient may desire additional services above and beyond the services provided by personal/respite care which the family or other support system is unable to provide. "Additional services" are defined as those tasks not usually covered by personal/respite care, such as companion care (for an individual who does not require 24-hour care) and heavy household cleaning. This additional care may be purchased by the recipient and/or family from any source, including the personal/respite care agency, or provided through other programs such as Medicare or Title XX.

The personal/respite care record must contain reference to any other service(s) received by the recipient regardless of the source of payment. However, an agency that provides more than one service to an individual should ensure that documentation of each service is maintained separately.

REFUSAL OF PERSONAL/RESPITE CARE SERVICES BY THE RECIPIENT

Recipients have the right to refuse services. This refusal must be documented by the aide on the aide's daily records. If all services for the day are refused, the aide should leave the home earlier than scheduled and document the early departure time. If services are refused frequently, a reduction in hours may be warranted (see Chapter V, "Decrease in Personal/Respite Care Hours by the Provider Agency" and "Decrease in Hours ").

The agency may not bill Medicaid or the recipient for any time when services are scheduled, but the aide is not able to provide care (e.g., the aide arrives and the recipient is not home).

SCHEDULED SERVICES NOT PROVIDED

The personal/respite care aide is responsible for following the current Plan of Care as outlined in the DMAS-97A.

If services were not provided as scheduled, the provider agency should not add the unused hours to another day to "make up" the hours unless specific services in the Plan of Care (DMAS-97A) are to be provided which would account for additional hours. Any such change should be documented and a change to the Plan of Care initiated if such adjustments are routinely necessary.

HOSPITALIZATION OF RECIPIENTS

When a recipient is hospitalized, the provider should contact the hospital discharge planner or hospital social services department to facilitate discharge planning. If the recipient will not be returning to the home with personal care services, the provider is instructed to terminate services and send a DMAS-122 to the local Department of Social Services and the assigned analyst at DMAS which indicates the last date of service that the individual received.

When a recipient is **hospitalized, regardless of the length of stay in the hospital, and the provider is able to ascertain that the recipient continues to meet the waiver criteria and requires resumption of personal/respite care services**, the provider agency may resume service without an additional pre-admission screening. (If a change in hours is indicated, see Chapter V under "Decrease in Hours" and "Increase in Hours.")

LAPSE IN SERVICE, OTHER THAN FOR HOSPITALIZATION - 30 DAYS OR MORE

The provider agency must close to services any recipient who, for any reason other than hospitalization, does not receive services for 30 days or more. A new screening is not required for a recipient who has been terminated from personal/respite care when both of the following conditions are met:

a) The date of service resumption occurs within six months from the last date of service delivery and the recipient is requesting services from the provider that provided services prior to the most recent termination; and

b) The provider agency nurse supervisor is able to determine that the recipient continues to meet nursing facility or pre-nursing facility criteria, is at risk of nursing facility placement, and requires personal care in order to remain in the community.

To re-enroll the recipient into personal care services, the nurse supervisor must:

1) Conduct a home visit to assess whether the individual continues to meet waiver criteria. Document this information and submit this full assessment of the recipient's functional and medical status according to definitions and criteria in Appendix D and a Plan of Care (DMAS-97A) which shows the new effective date to the DMAS admission certification analyst; and

2) Submit a DMAS-122 to the local Department of Social Services indicating the date that services were resumed.

If the nurse supervisor has any concern that the recipient no longer meets the level of care criteria, the supervisor is advised to refer the recipient for a pre-admission screening.

If the recipient requests services from a new provider after a lapse in service which exceeds 30 days, a new pre-admission screening is required.

NURSING FACILITY OR REHABILITATION FACILITY TO PERSONAL/RESPITE CARE

Once a recipient has been admitted to a nursing or rehabilitation facility, regardless of the length of the stay there, a new pre-admission screening is required prior to resumption of Community-Based Care services. This screening evaluation will be completed by the local Pre-Admission Screening Committee in the locality of the nursing facility. Since many hospitals have nursing facility and rehabilitation units connected to the hospital, it is important to check with the hospital to assure that the recipient has been in the acute care portion of the facility prior to resuming personal care services.

CHANGE OF RESIDENCE

If a recipient's residence changes, the provider agency must record this in the recipient's record and notify the local Department of Social Services. This notification must be immediate and in writing.

PROVISION OF PERSONAL/RESPITE CARE SERVICES TO MORE THAN ONE RECIPIENT IN THE SAME HOUSEHOLD

The Pre-Admission Screening Committee will assess the needs of all authorized recipients independently and develop the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. The amount of time for tasks which could and should be provided for both recipients simultaneously, such as meal preparation, cleaning rooms, laundry, and shopping must be calculated as time for completion of the task for all recipients. The total time required for all the recipients in the household should then be totaled (each individual's time plus the congregate task time), and this is the total amount of time which can be allocated for all the recipients in the household. For example, if there are three recipients residing in a household and the time required for tasks which must be performed independently equal 1 hour for recipient A, 1.5 hours for recipient B and 2 hours for recipient C, and the time required to prepare meals and perform necessary household tasks for all three recipients is 1.5 hours, the maximum allowed time for all three recipients is 6 hours, which can be allocated evenly among all three recipients as Plans of Care which show 2 hours per person or differentiated according to the difference in the independent task time (i.e., 1.5 hours for A, 2 hours for B and 2.5 for C).

In this situation, the provider may not place more than one aide in the home simultaneously without obtaining approval from the DMAS analyst. Approval will be based on the heavy care needs of the recipients which precludes the ability of one aide in the home to care for all of the recipients authorized for care. In the above example,

the agency may choose to use two staff persons for the three recipients authorized for care, but the two aides' times may not overlap unless the agency is able to demonstrate that one aide cannot care for the recipients (e.g., recipient A is ambulatory and confused, and one aide cannot provide the necessary care for recipients B and C because of the disruption caused by A).

Whenever possible, it is desired that when more than one recipient is residing in a household, one provider agency be the provider of services for all recipients. However, the recipient has the right to choose a provider agency, and the aides for two or more persons could be from more than one provider agency. The policy regarding allocation of time for Plans of Care for more than one person in a household is the same, regardless of whether one provider or more than one is rendering care. If more than one provider is chosen, the providers are expected to consult on the development and ongoing coordination of services.

AGENCY-TO-AGENCY TRANSFERS

If a recipient transfers from one provider agency to another, the transferring agency will send to the new agency the following:

- Originals of the DMAS-95 or DMAS-113A, DMAS-96, DMAS-97 or DMAS-113B, and DMAS-300 (for respite only) and the most current Plan of Care (DMAS-97A);
- A current DMAS-122;
- The most recent utilization review analyst's authorization letter if hours exceed the maximum for the recipient's level of care;
- Copies of chart entries pertaining to the recipient's history and current status; and
- A statement or copy of the letter to the recipient giving the date the transferring agency is ending services and the reason for transfer.

The transferring agency must retain a copy of any material sent to the receiving agency. The receiving agency's RN must visit the recipient prior to the start of care, develop a new agency Plan of Care (DMAS-97A), and send a copy to the admission certification analyst in the DMAS Community-Based Care Section indicating the name of the original provider agency and the last date of service provided by that agency, the name of the agency receiving the transfer, and the effective date of the new agency's Care Plan. The receiving agency must also send a DMAS-122 to the local Department of Social Services to inform them that a change in provider has occurred. If the hours in the Plan of Care developed by the receiving agency exceed the previously developed Plan of Care, an explanation must be provided.

PERSONAL/RESPITE CARE TO NURSING FACILITY TRANSFERS

A new pre-admission screening is not required when the recipient in the community and receiving personal/respite care services requires admission to a nursing facility. Once a nursing facility bed has been located for the recipient, the RN supervisor at the personal care agency is responsible for updating the DMAS-95 to show the recipient's current functional status and medical/nursing needs. The RN supervisor must forward this updated DMAS-95, along with a statement regarding the reason that nursing facility placement is being sought and the nursing facility which has been chosen, to the DMAS pre-admission screening supervisor. DMAS will then complete the DMAS-95-MI/MR and the DMAS-96, obtain the physician review from the DMAS Medical Support Unit and forward the DMAS-95, DMAS-95-MI/MR and DMAS-96 to the nursing facility chosen by the recipient. DMAS will send the recipient a letter confirming that the nursing facility admission has been authorized, and will send a copy to the personal care provider.

NOTE: If the individual appears to have a condition of MI/MR which requires a Level II screening, DMAS will forward the completed DMAS-95 and DMAS-95-MI/MR to the local Community Services Board (CSB) for a Level II evaluation. The Level II process must be completed by the CSB according to its usual process. Upon receipt of the Level II determination from the State Mental Health/Mental Retardation Agency (MHMRA) that the individual can be admitted to a nursing facility, the CSB will forward the documentation to DMAS so that nursing facility authorization can be given. If the determination is that the individual cannot be admitted to a nursing facility, DMAS will issue a letter denying nursing facility admission and notifying the recipient of the appeal process.

The provider must notify (via the DMAS-122) the local Department of Social Services and the assigned analyst at DMAS of the date personal care services were terminated.

Upon review of the information submitted by the RN supervisor, if DMAS concludes that the recipient does not meet the criteria for nursing facility admission, DMAS will notify the recipient and provider agency that nursing facility admission is denied, and will give the reason that the recipient has been determined not to meet nursing facility criteria.